Monitor

Making the health sector work for patients

Strategic Workforce Planning Tool

Strategic workforce planning for FTs

Why is strategic workforce planning important for FTs?

- ✓ Staff competence and motivation are critical to all NHS services.
- ✓ Strategic workforce planning improves the quality of care delivered to patients by ensuring that your future workforce has the right capacity and skills, values and behaviours to meet future patient needs.
- ✓ The NHS workforce accounts for 70% of recurrent costs, and it is in the interests of patients that all NHS providers deploy their workforce in the most productive way. This includes not just improving skills, but also improving care.

What this document will help you with

- ✓ Improving the way you plan your future workforce requirements.
- ✓ Thinking about how you ensure you deploy people in the most effective way using the appropriate variety of skills, locations, etc.
- ✓ Identifying the changes that your trust itself can lead. These will happen alongside longer-term work that trusts will do with Health Education England (HEE) to ensure the training of correct numbers of healthcare professionals − a key part of strategic workforce planning for the NHS as a whole.

Workforce planning ranges over three distinct time horizons

Workforce planning

	Horizon 1: Short-term – operational	Horizon 2: Medium-term – tactical	Horizon 3: Long-term – strategic
Typical questions	Less than one year • How do we best deploy existing workforce and fill gaps caused by natural workforce evolution?	One year (upcoming budget year) • What people are needed in the coming year to accomplish our strategy?	2–5 years • What people are needed to accomplish long-term business strategies? • Where and when will these people be needed? • What skills/ qualifications/ competencies will they need?
Typical activities/ methodology	• Driven by headcount projections • Results in rota scheduling within day-to-day management	• Conducted within an annual budgeting process • Focus on training and professional development • Individual, small-scale recruitment and effective performance management	• Prioritising workforce planning within long-term business planning process

Strategic workforce planning is:

- Long-term-oriented
- Integrated with the organisation's strategic-planning processes
- Focused on the quality and size of workforce

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Strategic workforce planning at a glance

Overall approach

Future demand

- Number of staff, by specialty/cluster[1], required to meet patient demand and support strategic initiatives
- Key drivers:
  - changes in volume and characteristics of demand
  - changes in treatment technologies
  - quality initiatives
  - productivity initiatives
  - role-substitution initiatives

Future supply

- Projected clinical workforce capacity[1] (ie number of full-time equivalents, FTEs) on a specialty/cluster basis
- Key drivers:
  - baseline with current turnover, retirement, absence and vacancy rates
  - in-house training and development
  - uplift figures

Forecast gap and skills mismatch

Interventions to optimise workforce

- Identify actions required to close the gap
- Address skills mismatch and enable new ways of working
- Consider which services could be reconfigured to make optimal use of available workforce, keeping patient benefit as the objective

1 Use job clusters made up of people who are in (roughly) the same specialty area and of (roughly) the same seniority

The four stages in strategic workforce planning

1 Agree on approach and job clusters

- **Agree the principles of your approach**, and the staff clusters (units and specialties) that you will use:
  - Job clusters made of people who are in (roughly) the same specialty area and of (roughly) the same seniority
  - Clusters should reflect similarities between skills required in groups of the healthcare workforce (eg junior ward-based nurses)
- **Agree at what operational unit you will conduct the planning** (wards, specialties, divisions, services)
- **Begin stakeholder engagement** – those closest to the work will have important perspectives on what the future workforce needs will be

2 Model future workforce demand

- **Create a view of future workforce needs, by staff cluster,** based on clinical demand forecast made at the Forecast stage. This will incorporate:
  - changes in volume and characteristics of demand
  - changes in treatment technologies
  - policy direction that may affect mandatory staffing levels
- **Update this by taking into account the total net effect of all planned strategic initiatives:**
  - quality initiatives that may require additional staff
  - productivity initiatives that may reduce number of staff needed by removing wasteful practice
  - role substitution initiatives that change mix of staff needed

3 Model future workforce supply

- **Create a view of future supply, based on expected changes in your workforce** before any additional workforce-supply changes are undertaken:
  - current staff projected with expected turnover, retirement and vacancies
  - expected sickness and absence rates
  - expected non-clinical time per FT staff member (eg for holiday, training, admin, other)
  - planned in-house training that will enable staff to move between staff groups
  - career promotions at historical rates
  - uplift rates, which may already include non-clinical obligations, annual leave, training, etc. Avoid double-counting these factors
  - staff performance against expectations

4 Plan actions to implement the required new workforce plan

- **Articulate the forecast gap** between workforce demand and supply by staff cluster/type, by specialty and for the trust as a whole
- **Plan how you will address the forecast gaps to implement the new workforce plan**. Strategic workforce initiatives can include:
  - new areas of focus for retention and recruitment
  - in-house training
  - shifting workforce across local health economy from other healthcare providers
- **Work with external stakeholders** where needed to support the changes
- **Provide forecasts to HEE** based on models of supply and demand
- **Think about how you will build in flexibility**

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Principles of the approach to workforce planning

1 **Agree on approach and job clusters** | 2 **Model future workforce demand** | 3 **Model future workforce supply** | 4 **Plan actions to implement the required new workforce plan**

A Agree principles of approach and share these with stakeholders

Principles underpinning an effective approach to workforce planning	Practical implications
• Workforce planning outputs should be aligned with service strategy	• Use service planning assumptions when developing workforce demand analysis
• Use fact-based and fully documented approach to analysis	• Analyse to specialty or specialty-cluster, documenting all assumptions
• Engage and challenge stakeholders	• Consult clinical professional and other expert groups
• Avoid ‘spurious accuracy’ (ie recognise these are estimates and judgements)	• Recommend adjustments only when the ‘gap’ is substantial (eg >15%); make incremental changes to training numbers
• Focus on actions and impact	• Don’t be put off by imperfect information or incomplete stakeholder buy-in
• Integrate latest view of financial and any other constraints	• Use tough efficiency assumptions, reflecting outlook for service funding
• Avoid under-supply – manage to marginal over-supply of staff and staff flexibility	• Identify how to develop flexible skills, working with clinical professional groups
• Minimise expenditure on agency staff	• Most trusts use agency staff for flexibility; however, reliance on agency staff is unlikely to be a sustainable solution

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Use job clusters to balance simplicity and detail

1 **Agree on approach and job clusters** | 2 **Model future workforce demand** | 3 **Model future workforce supply** | 4 **Plan actions to implement the required new workforce plan**

B Decide what level of analysis to use: apply to each directorate / specialty / division to create clusters

Approach

- Clusters should reflect specialty and role, and be more specific than the submission made to Monitor. They do not have to be exactly the same as those used in central returns and will typically be higher level.
- To choose the level at which to model roles (eg nursing staff, or senior and junior nursing staff, or nurses by band), consider what you need to use the workforce planning process for, how much data you have, and the resources available for the planning.
- If there have been difficulties in filling roles in the past or if the strategic initiatives will significantly change the requirements of your workforce, a more granular approach is appropriate.
- You will also need to choose the level to model the specialties at. If a specialty is undergoing significant change, or there are major shifts in the delivery model for some areas within it, then a more granular approach is appropriate.

Advantages of using clusters

- Keeps the number of assumptions limited
- Reflects similarities between skills required in groups of the healthcare workforce (eg junior ward-based nurses)
- Enables stakeholder engagement

From the outset design your approach with internal stakeholders, including clinical and managerial leads. Discuss what level of analysis to use in modelling the workforce.

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Choose the level of analysis

1 **Agree on approach and job clusters** | 2 **Model future workforce demand** | 3 **Model future workforce supply** | 4 **Plan actions to implement the required new workforce plan**

C Decide level for clinical and supporting workforce: apply to each directorate, specialty and division to create clusters

Doctors	Senior doctors	GPs			
		Consultants			
	Junior doctors	Registrars (ST3+)		Staff grades	
		FY1, FY2, CT1, CT2, ST1, ST2		Training posts	
Registered nursing, midwifery and health staff	Nurses	Band 2-4		Ward managers Managers	Typically use ‘Agenda for Change’ pay scales for analysing categories of staff other than doctors
		Band 5			
		Band 6-7			
		Band 8-9			
	Midwives	Band 2-4			
		Band 5		Entry-level midwives	
		Band 6-7			
		Band 8-9		Consultant midwives	
Qualified technical, therapeutic and scientific staff	Therapeutic	Band 2-4	Band 5		
		Band 6-7	Band 8 & 9	Superintendent radiographers	
	Technical	Band 2-4	Band 5		
		Band 6-7	Band 8-9	Higher management	
	Scientific	Band 2-4	Band 5	Entry-level biomedical scientists	
		Band 6-7	Band 8-9		

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Model future workforce demand (1/2)

1 Agree on approach and job clusters | 2 Model future workforce demand | 3 Model future workforce supply | 4 Plan actions to implement the required new workforce plan

A Demand (for workforce) by staff cluster driven by activity changes

- **Create a baseline view of workforce needs,** based on the clinical demand forecast made at the Forecast stage. This will not include the impact of new strategic initiatives, but will include the impact of strategic initiatives which are already underway and will affect staff requirements:
  - changes in volume and characteristics of demand
  - changes in treatment technologies

- **Create a view of workforce needs, taking into account the total net effect of possible strategic initiatives.** This is not expected to be a precise forecast. However, it should include the foreseeable impact of strategic initiatives to the extent possible. These may include:
  - quality initiatives that may require more/new/different staff
  - productivity initiatives that may safely reduce staff costs by improving ways of working
  - role-substitution initiatives that may change mix of staff needed
  - other workforce initiatives that may help your FT to achieve its strategic goals

On the following page is a simple template to capture conversations with clinicians and managers to understand how changes to their services will affect their future workforce needs

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Template for discussion

Specialty:

Questions

- **How will demand for care in your area change** over the next five years? [check against Demand forecast]
- **How will service delivery change** due to technological and clinical innovation and what will be the impact on workforce needs?
- Which **possible changes to quality and productivity** will affect workforce needs?
  - How can staff costs be reduced safely to support productivity initiatives, eg through use of technology, reducing duplication, moving towards more self-care by patients?
  - Where is there scope to explore role-substitution? Is everyone working at the maximum levels of autonomy for their registration?
- What changes in staff numbers and skills will be required to **implement other major planned strategic changes**?
- What are the **mandatory minimum staffing-levels** and how will these affect your service?
- What **other changes** could you make to your workforce to help achieve your strategic goals?

Initial estimates for this specialty

	Current numbers (2013/14)	Change 2014/15	Change 2015/16	Change 2016/17
Staff cluster 1				
Staff cluster 2				
Staff cluster 3				
Staff cluster 4				
Staff cluster 5				
Staff cluster 6				

Model future workforce demand (2/2)

B Create a view of workforce needs, taking into account the total net effect of all planned strategic initiatives

For each service, are any of the following changes planned? If so, you cannot assume that workforce needs will change in line with activity needs.

1. Investments to improve quality, for example:
   - 7-day access to services: this will require staff to work differently – for example, spreading core planned work over 7 days rather than over 5; while the total number of staff may not need to increase, rota arrangements and traditional ways of working will need to be reviewed
   - automation/improved process management to ensure more consistently high quality services may reduce the number of staff required
   - mandatory minimum staffing levels, which will in turn require a review of the way services are managed/organised to ensure optimum use of clinical time
2. Productivity/cost improvement plans will affect staff numbers through, for example:
   - direct staff productivity changes: removing duplication, downtime, unnecessary travel time, etc
   - length of stay reductions: modelling the impact not only of shorter stays but also the increased requirement for intensive care that may be required by a patient for the first 24 hours
3. Role-substitution plans (eg same clinical work being delivered by different staff groups through greater reliance on technology, through more self-service by patients), for example:
   - automation, eg remote interpretation and automated interpretation of diagnostics
   - self-service initiatives, eg self-booking of appointments would demand fewer secretarial staff; similarly, patients taking a greater role in managing their conditions or participating in group consultations
   - role-substitution within the same care-setting for same treatment can make better use of scarce and specialised resources, eg midwives rather than consultants giving epidurals; nurses rather than doctors giving eye-injections

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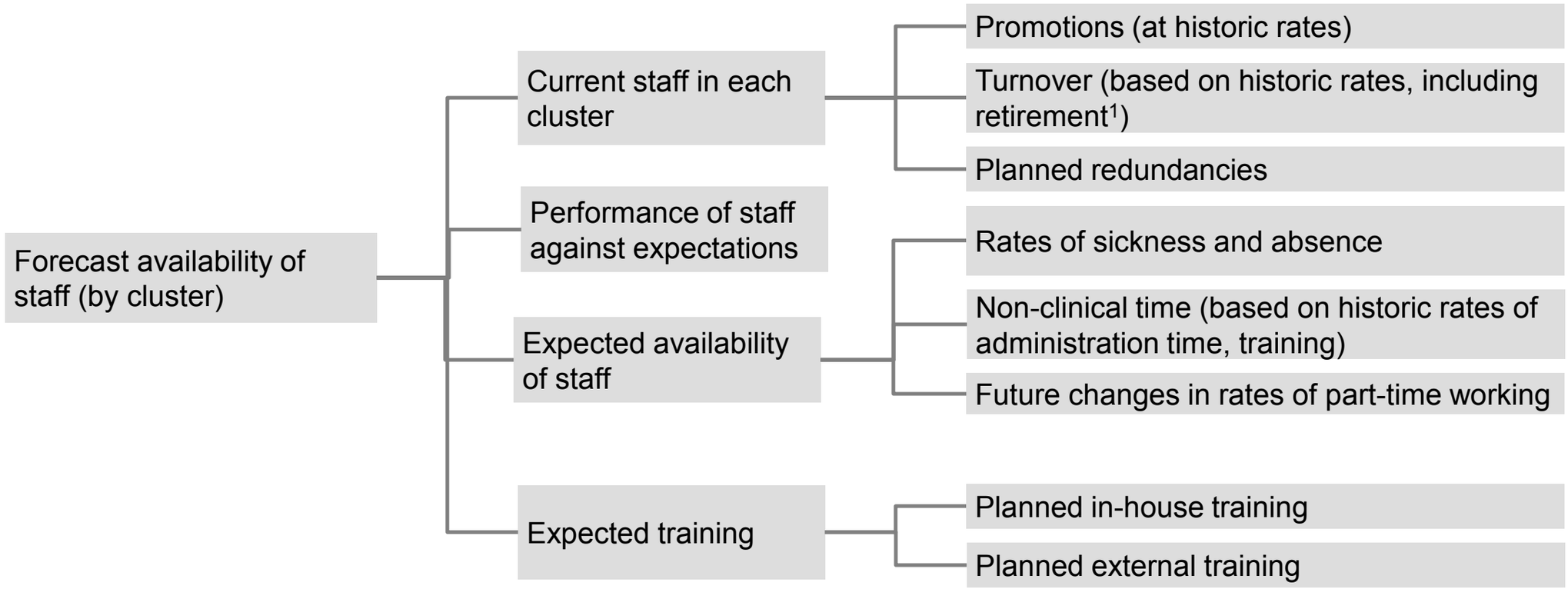
Model future workforce supply

1 Agree on approach and job clusters | 2 Model future workforce demand | **3 Model future workforce supply** | 4 Plan actions to implement the required new workforce plan

A Create a view of the current workforce supply

- Begin with current staff and expected trainee numbers
- Using historic rates of turnover, retirement and vacancies, create a forecast as your starting point



1 Retirement entitlements may vary according to employees' start dates; ensure you are working with the right assumptions on retirement rates

Plan how to close the forecast gap (1/2)

1 Agree on approach and job clusters | 2 Model future workforce demand | 3 Model future workforce supply | 4 Plan actions to implement the required new workforce plan

A Make strategic plans to close the workforce gap

Potential levers	Description
1 Retention and recruitment	• Reducing staff turnover may be important if you have found recruiting difficult in the past or have particularly high turnover. Initiatives might include increasing staff satisfaction, using exit interviews, financial incentives, or increasing staff. • Recruiting more staff in relevant areas may be necessary to address staff shortages. Examples of strategic shifts in workforce recruitment include targeted recruitment campaigns abroad, or recruiting trainees from the unregistered workforce.
2 Training, including new skill levels	• Train existing staff to improve skills and to improve staff retention rates. This may include 'grow-your-own' for areas where you find recruiting difficult , eg placing people in development roles and part-funding their training. Both internal and external training should be considered.
3 Improved job planning	• Changing the systems by which rosters are created, weekly job plans are made, etc, can help to increase efficiency and ensure staff are not overqualified for their allotted activities. This will also help with staff retention.

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Plan how to close the forecast 'gap' (2/2)

1 Agree on approach and job clusters | 2 Model future workforce demand | 3 Model future workforce supply | 4 Plan actions to implement the required new workforce plan

B Make strategic plans to close the workforce gap

Potential levers	Description
4 Reduce employee sickness and absences	• Reducing unplanned absences/employee sickness will reduce the necessary staffing levels; examples might include introducing self-scheduling for nurses' shift-work.
5 Improve performance management	• Effective performance management is both challenging and developmental. It also helps to retain the best individuals. Consider if your existing performance management arrangements are delivering improved performance against your measures.
6 Shift workforce within the local health economy	• Shift workforce between providers to reflect activity shifts. If you are taking over work from other healthcare providers, you may employ the staff who were working with the previous healthcare provider.
7 Work with Health Education England to change long-term supply	• Over the longer term, work with HEE to train the workforce. While the goal of this process is the creation of a strategic workforce plan, rather than the workforce plan you are required to submit, it should inform your submission. Over the longer term, your HEE submissions will affect the supply and help to close the gap.

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Flexible planning

1. Agree on approach and job clusters
2. Model future workforce demand
3. Model future workforce supply
4. **Plan actions to implement the required new workforce plan**

C

Make strategic plans to close the workforce gap

The Diagnose, Forecast and Generate Options sections of the Strategy Development Toolkit contain other examples of workforce analysis: the Diagnose stage provides examples of analysing current use of your workforce; the Forecast stage provides examples of how trusts can forecast future demand for care and understand future workforce needs; the Generate Options stage provides examples of innovative use of workforce as a strategic lever in itself.

In addition, the case study included on the next two pages from Moorfields Eye Hospital NHS FT is just one example of provider-led strategic workforce planning and development.

Flexibility/scenarios

In agreeing your principles, you will have established that strategic workforce planning involves a high-level picture of potential changes to address workforce requirements; you will have recognised that forecasts are approximate in nature and built on imperfect information.

These perspective should be kept in mind when you address the forecast workforce gap.

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Moorfields Eye Hospital NHS
NHS Foundation Trust

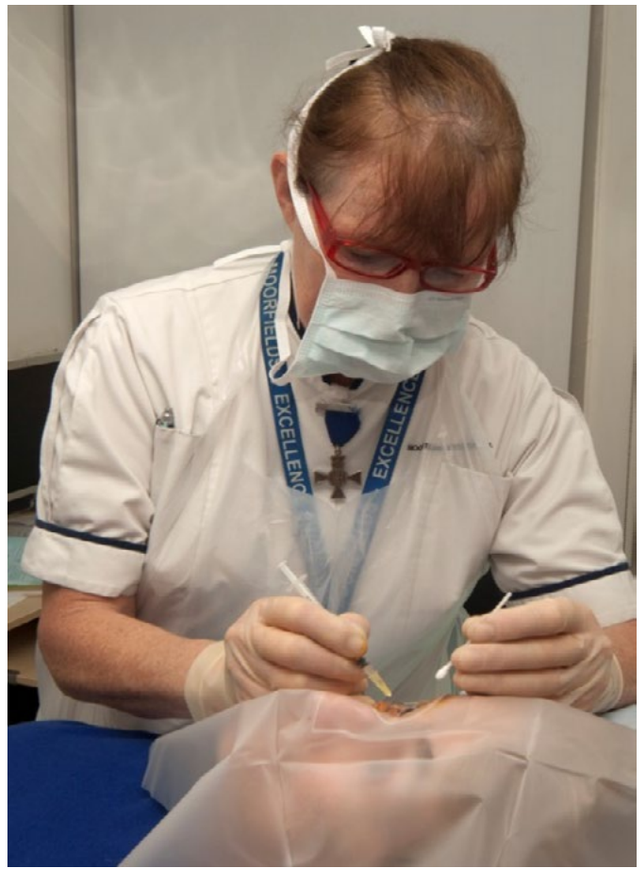
Case study: intravitreal therapy (IVT) (1/2)

Moorfields faced increasing demand for intravitreal injections

- Visual loss from neurovascular age-related macular degeneration (AMD) is projected to rise from 145,000 annually to 190,000 by 2020, due to the ageing population[1]
- In 2008, NICE approved the use of ranibizumab, an anti-vascular endothelial growth factor (anti-VEGF) drug, for AMD, leading to a dramatic rise in IVT2. In 2013, aflibercept was approved for the same purpose[2]
- The most common reason for patient safety incidents related to anti-VEGF drugs reported in England and Wales is delay in treatment or assessment[3]
- There is a limited supply of ophthalmologists in the UK – currently there are 5.2 per 100,000 population, the lowest ratio in the EU[1].

The trust decided to train senior nurses to deliver the drug

- Nurses already have extended roles within ophthalmic care, including substituting for ophthalmic surgeons in treatments such as laser capsulotomy treatment[4]
- Training nurses allows the service to become a 'one-stop' service where the injection is given on the same day that the decision to proceed with treatment is made
- The decision was taken to train senior nurses to deliver IVT



1 DaCosta, J., Hamilton, R., Nago, J., Mapani, A., Kennedy, E., Luckett, T., Pavesio, C., & Flanagan, D. (2014) *Implementation of a nurse-delivered intravitreal injection service*. Eye, 28 (6), 734-740

2 Michelotti, M.M., Abugreen, S., Kelly, S.P., Morarji, J., Myerscough, D., Boddie, T., Haughton, A., Nixon, N., Mason, B. & Sioras, E. (2014), *Transformational change: Nurses substituting for ophthalmologists for intravitreal injections - a quality improvement report*. Journal of Clinical Ophthalmology, 8, 755-761

3 Kelly, S. P. & Barua, A. (2011), *A review of safety incidents in England and Wales for vascular endothelial growth factor inhibitor medications*, Eye, 25 (6), 710–716

4 Forbes, M. (2013), *Bursting the bubblewrap: evolution and monitoring of nurse-performed Nd:YAG laser capsulotomy service*, International Journal of Ophthalmic Practice, 4 (4), 157

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Strategic Workforce Planning Tool

Moorfields Eye Hospital NHS
NHS Foundation Trust

Case study: intravitreal therapy (2/2)

Significant barriers were overcome

	Patient safety was a concern as nurse-delivered IVT had not yet been demonstrated to be safe and effective	Clinical evaluations demonstrated safe and effective results, comparable with clinical trials. Moorfields had no complications with the first 6,000 IVT cases
	Nurses at Moorfields were initially reluctant to volunteer	Emphasising the opportunity to learn and deliver better care resulted in nurses' volunteering
	The Royal College of Ophthalmologists had not previously endorsed the delivery of IVT by those other than ophthalmologists	Along with two other UK hospitals, Moorfields provided evidence from clinical evaluations to the Royal College of Ophthalmologists This led to the Royal College's guidance in July 2013 allowing IVT to be delivered by nurses, with appropriate training and supervision
	There was concern that patients would be uncomfortable having IVT performed by a nurse	10% of patients refused nurse treatment during the trial at Moorfields; after this period there were no further refusals. At the other test sites, there were no refusals[2]
LUCENTIS RANIBIZUMAB INJECTION	These IVT injections are only licensed for delivery by ophthalmologists; pharmaceutical providers have not yet asked licensing authorities to change this	Moorfields sought clarification from the NHS Litigation Authority, which agreed to indemnify against claims, provided that training is consultant-supervised, protocols are adhered to, there is a nurse injection policy, and outcomes are monitored

The result was improved patient satisfaction at lower cost

- Clinical quality:
  - the results of nurse-delivered IVT were comparable with ophthalmologist-delivered IVT[1]
- Efficiency:
  - Moorfields carried out 23% more intravitreal injections (16,400 in total) in 2013/2014, with 50% now being carried out by nurses
  - nurses are graded at band 7, which compares favourably with the cost of clinical fellows, specialty doctors, or consultants
- Patient satisfaction:
  - the 'one-stop' service has reduced waiting for patients, which had been the biggest cause of complaints

1 Michelotti, M.M., Abugreen, S., Kelly, S.P., Morarji, J., Myerscough, D., Boddie, T., Haughton, A., Nixon, N., Mason, B. & Sioras, E. (2014), *Transformational change: Nurses substituting for ophthalmologists for intravitreal injections - a quality improvement report*. Journal of Clinical Ophthalmology, 8, 755-761

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